CULLMAN REGIONAL | Medical Group

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1912 Alabama Highway 157, Main Hospital
Ground Floor Cullman, AL 35058
Phone 256-737-2095
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CARDIOLOGY REFERRAL FORM

Patient name _____

DOB_____ Phone _____

Height_____ Weight _____

Address _____

_____

Primary Insurance _____

Policy _____

Referral authorization # if required _____

Please include clinical documentation such as imaging, lab work, clinic notes, if available.

Please include the following documents

Referral form

Demographic sheet

Insurance referral (if needed)

Office note(s) with documentation for visit

Any previous cardiac testing (especially if abnormal)

DIAGNOSIS/INDICATIONS

☐ Leg Pain
☐ Shortness of breath
☐ Stroke
☐ Pulmonary HTN
☐ Chest Pain Evaluation
☐ Syncope
☐ Palpitation
☐ Dizziness
☐ Peripheral Arterial Disease
☐ Other _____ ☐ Allergies_____

ORDERING PROVIDER

Physician _____

Phone_____ Fax _____

Provider Signature _____

Appt. Date and Time _____

Patient notified on _____

Physician offices will be notified when appointments are scheduled and notification is confirmed for all diagnostic procedures

Please include insurance referral, if required.

Phone 256-737-2095 · Fax 256-737-2097